EMT-I REGULATORY TASK FORCE
MEETING MINUTES
April 24, 2000 – San Diego

I. Introduction

Members in attendance:

From the EMS Authority:
Maureen McNeil
Bev Skillicorn
Nancy Steiner
Richard Watson

Anne Bybee, CPPD North
Jolene DeGroot, CDF/State Fire Marshal
Elaine Dethlefsen, CA Council of EMS Educators
Tom McGinnis, Ca Ambulance Association
Bruce Haynes, MD, EMDAC
Pat Kramm, Educational Technical Advisory Panel for the Commission on EMS
Debbie Meier, Nor-Cal Fire Chiefs
Debi Moffat, CPPD – South
John Pritting, EMSAAC
Marco Randazzo, MD, Cal/ACEP
Susan Smith, CA Emergency Nurses Association
Kevin White, CA Professional Firefighters

Alternates in attendance:

Bruce Kenagy, CA Assn of Health Maintenance Organizations
Karen Petrilla, CA Council of EMS Educators
Aaron York, CHP

Members absent:

Nancy Casazza, CA Nurses Association
Donna Ferracone, Public Member
Gloria Huerta, So. CA Fire Chiefs
Sally McGregor, CDF/State Fire Marshal
Debra Meier, No. CA Fire Chiefs
Bob Repar, CA Peace Officers Association
Todd Wilhoyte, EMT-P Service Employees

II. Approval of Minutes

Minutes from the March 16, 2000 Conference Call meeting were reviewed and approved as submitted.

III. Business Items

Old Business

New Business

A. Group drafted the following list of action items for task force review:

1) Statewide Standardization
   - Curriculum/Hours (didactic, clinical and field)
   - Testing (written and skills) - NREMT
   - Certification/Licensure
   - Accreditation – where necessary
   - C.E. Criteria

2) Consistency in terminology (i.e. EMT-1 versus EMT-Basic or EMT-B; licensure versus certification

3) Training Program Staff Requirements/Qualifications
   - Program Director and Instructor Qualifications
4) Optional/Expanded Scope
   - Trial Studies
   - Medications
   - EMT-II
5) Disciplinary Process (Standardization)

A brief discussion followed on how the task force prefers to proceed on these projects. Small group option was discussed and dismissed; members present felt that broad representation was critical at this stage of development.

B. Prior to working on curriculum, it was agreed that a review of EMT-I Scope of Practice was necessary:

1) Section 100063 (p. 4, lines 11 – 36) regarding items identified as optional to the Medical Director of the local EMS agency: it has been suggested that this list be moved to the standard scope of practice for EMT-I. It was further recommended that the list of medications (p. 4, lines 21 – 22) be limited to routine and not-new-to-patient categories.
2) In Optional Skills, section 10064 (p. 6, line 2) it was stated that the Medical Directors support the use of the Combitube, but have a concern with endotracheal intubation by EMT-Is
3) Discussion on AED and SAED: Scope of practice, section 10056 (page 1, lines 3 – 8) identifies authorization to use equipment that is either automatic or by user-interaction. Group agreed that the regulations are confusing on this issue,

mixing AED service providers, AED/SAED use, and AED/SAED training. Recommendation: clarify intent in all areas.

4) Trial Studies, section 100064.1 (page 8, beginning with line 6): Discussion on whether advanced proedures/medications from the trial study in Imperial County should be added to Optional Scope of Practice. It was stated that the Medical Directors are divided on where to locate this in the regulations (both scope and training). Action item: Dr. Bruce Haynes offered to draft two alternatives on an Advanced EMT-1 Program to cover these ALS skills in the EMT-I realm. Seven items from the Imperial County EMT-I Advanced Trial Study proposed for addition under optional scope for EMT-I. Should the seven items be a package component or should local EMS agencies be able to pick and choose from the seven items? Should it be allowed for rural areas only?
5) Suggested additions to the EMT-I Basic Scope:
   - Epinephrine administration
   - Glucose Monitoring (Glucometer)
   - Albuterol
   - Magill Forceps w/Intubation
6) Demonstration of skills competency for use of the Combitube (page 6, lines 32 – 34) – question: should this be a local decision or should competency and ongoing training/testing be decided at the state level?

C. Curriculum: Group discussed the need to compare Title 22 (current regulations) with the new DOT curriculum. It was agreed that this may be an impossible task as terminology, etc., are not necessarily consistent. It was suggested that perhaps a better approach would be to look at our state Scope of Practice and compare **this** to the new DOT curriculum, making a list of items we would need to add to the DOT curriculum for our state curriculum. Action item: work group consisting of Nancy Steiner, Maureen McNeil, Aaron York, Lois Williams and Anne Bybee offered to do this task on Tuesday, May 2nd at the State EMSA office, 9:00 a.m. Results will be distributed to committee members prior to the next task force meeting.

D. Clinical/Field Hours, section 100074: Group attempted to identify our objectives with this portion of the EMT-I training program (observation? Competency in skills?). Recommendations:

1) Maintain 10-hour minimum requirement
2) Increase patient contact requirement to 5 (up from 3)
3) Drop option to simulate patient contact in classroom
4) Broaden clinical options (section 100068) to include Skilled Nursing Facilities, Rehabilitation Centers, Convalescent Homes, etc.).
5) Have a clear definition of a “patient contact”.
6) Do case histories for clinical patient contacts.

E. Testing: Concerns with the current system:

1) Exams vary from county to county
2) Exams are not always current
3) Multiple or validated Certifying Agencies including Public Safety Agencies

4) Who administers exams varies from county to county

The task force identified the desire to have standardized testing and agreed to look at National Registry as an option. It was suggested that we invite representatives from National Registry to a future meeting to discuss this possibility. Some concerns were raised about National Registry:

1) There does not appear to be adequate customer service to handle applicants questions, phone calls, problems, etc.
1) The exam has an extremely broad scope that may not be applicable to the EMT-I in the State of California.

Support for NREMT exams was also expressed.
A question was raised as to whether we should consider dropping the requirement for EMT-1s to retest every four years. The concern in dropping this is how would we check/verify retention and competency of skills.

F. Licensure: The following questions were raised:

1) Should the State EMSA handle EMT-I licensure?
2) Should background checks be required by licensing agencies?

G. Terminology: It has been suggested that we change from term EMT-I to EMT-B, which is the term used more consistently throughout the country, and in the National DOT curriculum. The problem that has been encountered is that EMT-I is often misinterpreted as EMT-Intermediate (in California referred to as EMT-II).

IV. Dates for next meetings:

May 25, 2000 – Alameda, 10:00 – 4:00
June 19, 2000 – San Diego, 10:00 – 4:00